Senate

General Assembly

File No. 429

February Session, 2012

Substitute Senate Bill No. 425

Senate, April 16, 2012

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING A BASIC HEALTH PROGRAM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) (a) Not later than January 1, 2014, the Special Advisor to the Governor on Healthcare Reform, in consultation with the Commissioner of Social Services, shall, within available appropriations, establish and implement a basic health program in accordance with Section 1331 of the federal Affordable Care Act. On and after January 1, 2014, all individuals under sixty-five years of age with income not exceeding two hundred per cent of the federal poverty level, and who are ineligible for medical assistance pursuant to Title XIX of the Social Security Act, and otherwise eligible for medical assistance under Section 1331 of the Affordable Care Act, shall be eligible for medical assistance under a basic health program. For purposes of this section and section 5 of this act, "Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act, P.L. 111-152, as both may be amended from time to time, and

regulations adopted thereunder.

(b) Medical assistance provided through the basic health program shall include the benefits, limits on cost-sharing and other consumer safeguards that apply to medical assistance provided in accordance with Title XIX of the Social Security Act, unless the special advisor determines that the cost of medical assistance provided to enrollees in the basic health program will exceed the federal subsidies available to the state to fund the program. If the special advisor so determines, the special advisor, in consultation with the commissioner, shall develop and submit a plan, in accordance with section 2 of this act, for the basic health program that maximizes benefits and minimizes cost-sharing, utilizing funds available from federal subsidies and not using state funds to fund the program.

(c) To the extent that federal funds received for the basic health program exceed the cost of medical assistance that would otherwise be provided to program enrollees pursuant to Title XIX of the Social Security Act, the Commissioner of Social Services, to the extent permitted under federal law, shall use the excess of such federal funds to increase reimbursement rates for providers serving enrollees receiving benefits pursuant to the basic health program. The Commissioner of Social Services, in consultation with the special advisor, shall increase reimbursement rates so as to maximize access to needed health services. The Commissioner of Social Services, in consultation with the special advisor, shall establish a committee charged with making recommendations to (1) keep provider rates competitive, (2) provide payment incentives that increase access to primary care offices as an alternative to emergency room care, and (3) streamline paperwork. The committee shall be comprised of representatives of the Department of Social Services, Office of Health Reform and Innovation and providers who participate in the basic health program and Medicaid.

(d) The Special Advisor to the Governor on Healthcare Reform, in consultation with the Commissioner of Social Services, shall take all

necessary actions to maximize federal funding and seek any necessary approvals from the federal government in connection with the establishment of a basic health program.

Sec. 2. (*Effective from passage*) (a) Not later than November 1, 2012, the Special Advisor to the Governor on Healthcare Reform, in consultation with the Commissioner of Social Services, shall submit a plan for the establishment and implementation of a basic health program to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, and appropriations and the budgets of state agencies.

(b) Not later than thirty days after the date of their receipt of such plan, the joint standing committees shall hold a public hearing. At the conclusion of the public hearing, the joint standing committees shall advise the special advisor of their approval, denial or modifications, if any, of the plan.

(c) If the joint standing committees do not concur, the committee chairpersons shall appoint a committee of conference which shall be composed of three members from each joint standing committee. At least one member appointed from each joint standing committee shall be a member of the minority party. The report of the committee of conference shall be made to each joint standing committee, which shall vote to accept or reject the report. The report of the committee of conference may not be amended. If a joint standing committee rejects the report of the committee of conference, that joint standing committee shall notify the special advisor of the rejection and the special advisor's plan shall be deemed approved. If the joint standing committees accept the report, the committee having cognizance of matters relating to appropriations and the budgets of state agencies shall advise the special advisor of their approval, denial or modifications, if any, of the special advisor's plan. If the joint standing committees do not so advise the special advisor during the thirty-day period, the plan shall be deemed approved. Any plan submitted to the federal government pursuant to this section shall be in accordance

with the approval or modifications, if any, of the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, and appropriations and the budgets of state agencies.

Sec. 3. Subsection (a) of section 17b-261 of the 2012 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (e) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917(c) of the Social Security Act, 42 USC 1396p(c), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a family unit of equal size with no income under the temporary family assistance program in the appropriate region of residence. Except as provided in section 17b-277, the medical assistance program shall provide coverage to persons under **[**the age

of**]** nineteen years of age with family income up to one hundred eighty-five per cent of the federal poverty level without an asset limit and to persons under **[**the age of**]** nineteen years of age and their parents and needy caretaker relatives, who qualify for coverage under Section 1931 of the Social Security Act, with family income up to one hundred eighty-five per cent of the federal poverty level without an asset limit. On and after January 1, 2014, and contingent upon the implementation of a basic health program with the same benefits, limits on cost sharing and other consumer safeguards provided under Title XIX of the Social Security Act, coverage shall be provided to parents and needy caretaker relatives of persons under nineteen years of age, who qualify for coverage under Section 1931 of the Social Security Act, with family income up to one hundred thirty-three per cent of the federal poverty level without an asset limit. Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of (1) the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance, (2) the effect that having income that exceeds the limits prescribed in this subsection will have with respect to program eligibility, and (3) the availability of, and eligibility for, services provided by the Nurturing Families Network established pursuant to section 17b-751b. Persons who are determined ineligible for assistance pursuant to this section shall be provided a written statement notifying such persons of their ineligibility and advising such persons of the availability of HUSKY Plan, Part B health insurance benefits.

Sec. 4. (*Effective from passage*) For the fiscal years ending June 30, 2014, and June 30, 2015, fifty per cent of any savings from reducing coverage for HUSKY Plan, Part A parents and needy caretaker

relatives to those with family incomes not greater than one hundred thirty-three per cent of the federal poverty level shall be used to increase reimbursement rates for providers serving individuals receiving benefits pursuant to the basic health program. Reimbursement rates shall be increased pursuant to this section so as to maximize individuals' access to needed health care services.

Sec. 5. (NEW) (*Effective from passage*) There is established an account to be known as the "basic health program account", which shall be a separate, nonlapsing account within the General Fund. The account shall contain any moneys required by law to be deposited in the account. Moneys in the account shall be expended by the Commissioner of Social Services, in consultation with the Special Advisor to the Governor on Healthcare Reform, for the purposes of operating a basic health plan in accordance with Section 1331 of the Affordable Care Act.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*from passage*	New section
Sec. 2	*from passage*	New section
Sec. 3	*from passage*	17b-261(a)
Sec. 4	*from passage*	New section
Sec. 5	*from passage*	New section

Statement of Legislative Commissioners:
In section 1(c), in the first sentence, "commissioner" was changed to "Commissioner of Social Services" for consistency of reference in said section; in the second sentence of section 2(b), "a public hearing" was changed to "the public hearing," for clarity; and in the last sentence of section 5, "in conformance with" was changed to "in accordance with" for accuracy and statutory consistency.

PH *Joint Favorable Subst.*

OFA Fiscal Note

State Impact: See below

Municipal Impact: None

Explanation

Overview

The bill requires the Special Advisor to the Governor on Healthcare Reform, in consultation with Department of Social Services (DSS), to establish, by January 1, 2014, a basic health program (BHP) for adults with incomes from 133% of the federal poverty level (FPL) to 200% FPL.[1] The cost of this program is to be limited to the federal subsidies available under the Patient Protection and Affordable Care Act (PPACA). The bill results in the impact described below based on the following factors: 1) annualized health and administrative costs of BHP enrollees, 2) HUSKY A population, and 3) federal premium and cost sharing subsidies.

In summary, the annualized health and administrative cost, assuming the total eligible population enrolls in the BHP, is estimated between $497.3 million and $825.4 million (as detailed below). The bill requires the program to be operated within available federal subsidies. It is unknown at this time what the value of the federal subsidies will be to offset these costs. Should the subsidies not cover the full cost of the BHP, the bill requires the Special Advisor to reduce the BHP plan cost so as to remain within the available federal subsidy. Any such action would likely include a combination of reduced provider rates, reductions to benefits, or increased premiums and/or cost sharing for

[1] In 2012, 133% FPL – 200% FPL is $14,856 to 22,340 for a single person.

enrollees. The bill requires that any BHP plan modifications must be approved by the General Assembly. Should the federal subsidies exceed the costs of the BHP plan, the bill requires DSS to use these funds to increase the provider rates under the program.

Should current BHP eligible enrollees of the HUSKY A program transition to the BHP, the state would realize annualized savings of $72.85 million. For the fiscal years of FY 14 and FY 15, the bill specifies that half of these savings be used to increase BHP provider rates. The bill also creates a non-lapsing basic health program account. The bill imposes certain restrictions for the HUSKY A population which will impact the ability of the state to achieve savings from this population depending on the structure of the BHP and any actions taken by the agency to keep costs even with federal subsidies.

Federal Subsidies

Under PPACA, the state will receive a federal subsidy for those residents enrolled in the BHP. For FY 14, this subsidy is equal to 95% of what the federal government would have spent on premium tax credits and cost sharing reductions that BHP enrolled individuals would have been eligible for had they purchased private insurance through the State Insurance Exchange.[2] The tax credits and cost sharing reductions are based on the "Silver Plan" on the insurance exchange.

At this time, the federal government has not determined what the final essential benefit package will be, which will dictate both the cost of the Silver Plan and the value of the associated federal subsidy. From January 1, 2014 until January 1, 2016, the federal government has given the state responsibility to determine the essential benefit package (EHB).[3] Until the state chooses an EHB, the aggregate amount of the

[2] The federal government has the option of changing the percentage of this subsidy in subsequent years.

[3] The state may choose between one of the three largest state employee health plans (by enrollment); one of the three largest federal employee health plan options; the

per person subsidy available to offset the BHP program costs is not known. It is uncertain what the impact will be to subsidies when the federal government reevaluates the EHB in 2016.

In addition, the mechanism for distributing the subsidy to the states has not been established. To the extent that costs are incurred before receipt of the subsidy, these costs may be the initial responsibility of the state.

Population Estimate

The bill specifies that all adults under the age of 65 with incomes between 133% FPL and 200% FPL are eligible for the BHP. The BHP may also include parents of children currently enrolled in the HUSKY A program who's incomes fall within this range (please see section on HUSKY A adults below).

Assuming that the HUSKY A parents are enrolled in the BHP, the program is expected to have 103,100 eligible enrollees in total.[4] Should the HUSKY A parents not enroll due to any benefit adjustments or cost sharing, the eligible population would be 72,100.

Health Cost Estimate

The BHP is required to have the same benefits and cost sharing as the Medicaid program (unless federal subsidies do not cover the cost of the program, discussed below). It is likely that should the approximately 31,000 eligible HUSKY A adults transfer to the BHP, their costs would be relatively similar in both programs. Based on DSS

largest HMO plan offered in the state or one of the three largest small-group plans in the state.

[4] This assumes 31,000 former HUSKY A parents and 72,100 non-HUSKY adults. According to Connecticut Department of Revenue Services data, there were approximately 202,000 tax filers with incomes between $14,856 and $21,660 in 2010. The U.S. Census Bureau estimates that 29% of individuals with incomes under $25,000 are uninsured. This would yield approximately 58,600 individuals. It is further assumed that 13,500 of those in this income bracket who currently have insurance would likely transition to BHP, for a total of 72,100 non-HUSKY BHP potential enrollees.

cost data for this group, it is estimated that they would represent a FY 14 cost of $145.7 million.[5]

The cost profile of the non-HUSKY A BHP enrollees is not known.[6] However, it is likely to include certain individuals with significantly higher cost profiles than the relatively young HUSKY A adults.[7] The table below illustrates three potential cost scenarios in addition to the HUSKY A adults discussed above. First, if the non-HUSKY A adult population (72,100) has a cost profile equal to that of HUSKY A adults, there would be a FY 14 cost of $4,700 per person. Second, if the population has a cost profile approximately 20% above the HUSKY A population, there would be a FY 14 cost of $5,640 per person. Third, should the cost reflect the recent experience with the Medicaid Low Income Adult (LIA) population, there would be a FY 14 cost of $9,250 per person. [8] Based on these cost and the caseload assumptions, the range of costs to enroll all eligible individuals would be as follows:

	HUSKY A	**Non-HUSKY A**		
	HUSKY A BHP	Scenario 1	Scenario 2	Scenario 3
Cost per Case ($)	4,700	4,700	5,640	9,250
Estimated Number Cases	31,000	72,100	72,100	72,100
Total Cost	145,700,000	338,870,000	406,644,000	666,925,000
Combined BHP Cost		**484,570,000**	**552,344,000**	**812,625,000**

Even with the individual mandate included in PPACA, it is unlikely that 100% of the eligible individuals would enroll in the BHP. Therefore, the cost range noted above would be proportionately lower

[5] Based on DSS health cost data, inflated at 5% annually, there is a per person cost of $4,700. (Source: An Analysis of Health Insurance Premiums under the Patient Protection and Affordable Care Act, CBO, November 30, 2009).

[6] Although numerous studies have produced comparative per person cost estimates for this population, the following estimates are based on actual Connecticut Medicaid expenditures in order to properly reflect the Connecticut benefit package and rate structure.

[7] A portion of high cost Medicaid clients who currently use their own resources to spend down to Medicaid eligibility may instead be able to enroll in the BHP. There is also likely to be a pent up demand for services among previously uninsured and underinsured enrollees.

[8] Current annual LIA cost of $8,400, inflated by 5% per year until FY 14.

based on whatever enrollment rate is achieved.

Administrative Cost Estimate

The cost figures noted above are based on fee-for-service claims data from DSS. There would also be significant administrative costs related to a BHP expansion. DSS has recently moved Medicaid recipients into a non-risk administrative service organization (ASO) system. Based on the Governor's recommended FY 13 budget adjustments, there is a per member, per month administrative cost of $10.30 under the ASO. Should the administrative cost profile for the BHP be similar, there would be an additional annualized cost of up to $12.74 million.

HUSKY A State Savings

The bill requires current HUSKY A adult enrollees with incomes between 133% and 185% FPL to move to the new BHP, if the BHP has the same benefits, limits on cost sharing and other consumer safeguards as the Medicaid program. Under the Medicaid program, the state and federal government currently equally split the cost of these HUSKY A clients. Therefore, by moving these clients to a BHP that is to be fully supported by federal subsidies, the state would save approximately $72.85 million annually. Should the HUSKY A clients not move to the BHP due to any BHP benefits, limits on cost sharing and other consumer safeguards that are not the equal of Medicaid, the state would not realize these savings.

Section 5 of the bill specifies that half of this potential savings in both FY 14 and FY 15 must be used to increase BHP provider rates.

The Out Years

The bill requires the Basic Health Program to be established and implemented by January 1, 2014, resulting in the impact described above. Although the bill specifies that the cost of the BHP is limited to the federal subsidies available under PPACA, such subsidies are subject to change when the federal government reevaluates the

essential benefit package after 2016.

OLR Bill Analysis
sSB 425

AN ACT CONCERNING A BASIC HEALTH PROGRAM.

SUMMARY:

This bill requires the special advisor to the governor on healthcare reform (hereafter referred to as "special advisor"), in consultation with the Department of Social Services (DSS) commissioner, to establish and implement a Basic Health Program (BHP) in accordance with the 2010 federal Patient Protection and Affordable Care Act. She must do this by January 1, 2014, and within available appropriations.

Under the bill, the program provides subsidized health insurance to individuals (1) with incomes up to 200% of the federal poverty level (FPL), (2) under age 65, and (3) who do not qualify for Medicaid and otherwise meet the BHP program's federal eligibility criteria. Individuals in the BHP would be ineligible to obtain health insurance through the state's health insurance exchange, which the state must establish by 2014 (see BACKGROUND). The federal government largely subsidizes the BHP's costs.

The bill:

1. requires the BHP to offer Medicaid-equivalent benefit levels and cost-sharing limits, unless it will cost the state more than it receives in federal subsidies;

2. moves certain HUSKY A adult recipients into the BHP provided they maintain the same benefit levels and cost-sharing limits (currently they pay no cost sharing);

3. requires the special advisor to (a) submit a BHP implementation

plan to the Appropriations, Human Services, and Public Health committees for their approval and (b) take all necessary steps to maximize federal funding and seek any necessary federal approval in connection with establishing the BHP; and

4. establishes a separate, nonlapsing General Fund account for the federal BHP subsidies.

The bill also requires the DSS commissioner to use (1) 50% of the anticipated savings from moving the HUSKY A adults into the BHP in FY 14 and FY 15 and (2) any BHP federal subsidies the state receives that exceed the cost of providing Medicaid-equivalent coverage to increase BHP provider reimbursement rates.

EFFECTIVE DATE: Upon passage

BASIC HEALTH PROGRAM (BHP)

Program Benefits and Cost Sharing (§ 1(b))

The bill requires the BHP to provide the same benefits, cost-sharing limits, and other consumer safeguards that apply to Medicaid recipients, unless the special advisor determines that doing so will cost more than the federal subsidies available to the state to pay for the BHP.

If the special advisor makes such a determination, she must, in consultation with the DSS commissioner, develop and submit a plan that maximizes benefits and minimizes cost sharing in order to run the BHP within available federal subsidies and not use any state funds. The plan must be submitted in accordance with the bill's reporting requirements (see § 2).

BHP Plan (§ 2)

The bill requires the special advisor, in consultation with the DSS commissioner, to submit a plan to establish and implement the BHP to the Appropriations, Human Services, and Public Health committees by November 1, 2012.

The committees must hold a public hearing on the plan within 30 days of receiving it. At the hearing's conclusion, they must advise the special advisor of their approval, denial, or modification of the plan.

If the committees do not concur, the bill requires their chairpersons to appoint a conference committee composed of three members from each committee. At least one member from each committee must be from the minority party.

The conference committee must report to each standing committee, which must vote to accept or reject the report without any amendments. If any committee rejects the conference committee's report, it must notify the special advisor and the plan is deemed approved. (It appears the only way the plan can be rejected is if all three committees vote to do so.) If the committees accept the report, the Appropriations Committee must advise the special advisor of their decision to approve, deny, or modify the plan within the 30-day period, otherwise the plan is deemed approved.

The bill specifies that any plan the special advisor submits to the federal government must be in accordance with the committees' actions.

Eligibility for HUSKY A Adults (§ 3)

Starting January 1, 2014, the bill eliminates HUSKY A eligibility for caretaker adults with income over 133% of the FPL. This in effect makes adults with incomes between 133% and 200% of the FPL who would otherwise qualify for HUSKY A eligible for the BHP. (Under current law, HUSKY A is available to caretaker adults of children receiving HUSKY A with family income up to 185% of the FPL.)

The bill expressly states that this reduction in income limit occurs only if the state implements a BHP that offers the same benefits, cost-sharing limits, and other consumer safeguards offered under Medicaid.

Use of HUSKY A Adult Savings (§ 4)

For FY 14 and FY 15, the bill requires 50% of any savings from limiting the income eligibility for HUSKY A caretaker adults to 133% of the FPL to be used to increase BHP provider reimbursement rates. Rates must be increased to maximize access to needed health care services.

Use of Excess Federal Subsidies (§ 1(c))

To the extent federal law allows, the bill requires any federal subsidies the state receives for the BHP that exceed the cost of providing the Medicaid-equivalent coverage to BHP enrollees to be used to increase BHP provider reimbursement rates. The DSS commissioner, in consultation with the special advisor, must increase the rates in a way that maximizes access to needed health care services.

The bill requires the commissioner, in consultation with the special advisor, to establish a committee to make recommendations to (1) keep provider rates competitive, (2) provide payment incentives to increase access to primary care offices as an alternative to emergency room care, and (3) streamline paperwork. The committee consists of DSS and Office of Health Reform and Innovation (OHRI) representatives and health care providers serving Medicaid and BHP enrollees.

BHP Account (§ 5)

The bill establishes a BHP account as a separate, non-lapsing account in the General Fund to hold any moneys the law requires to be deposited into it. The DSS commissioner, in consultation with the special advisor, must spend the funds to operate the BHP, in accordance with federal law.

BACKGROUND

Related Bill

sHB 5450 (File 315), favorably reported by the Human Services Committee, similarly requires the DSS commissioner to establish and implement a BHP by January 1, 2014.

BHP

Section 1331 of the 2010 federal Patient Protection and Affordable Care Act (PPACA, PL 111-148) allows states, beginning in 2014, to establish BHPs for individuals (1) ineligible for Medicaid, (2) under age 65, (3) with household income between 133% and 200% of the FPL (individuals with incomes under 133% of the FPL qualify for Medicaid), and (4) ineligible for minimal essential health care coverage (e.g., State Children's Health Insurance Program (HUSKY B in Connecticut)) or who cannot afford their employer's coverage.

The federal law imposes cost-sharing limits and requires that state BHPs provide benefits at least as rich as those in the state's "essential health benefits package" available to someone purchasing insurance through its health insurance exchange.

States that operate a BHP are eligible for federal subsidies equaling 95% of the premium tax credits and cost-sharing reductions that the federal government would have spent if BHP enrollees had received their assistance when enrolling in an exchange health plan. (Connecticut receives a 50% federal match for its health care expenditures under Medicaid.)

The law requires states to establish funds into which the federal subsidies are deposited and can be used only to reduce BHP enrollees' premiums and cost sharing or to provide them with additional benefits (42 § USC 18051).

Health Insurance Exchange

A health insurance exchange is a set of state-regulated and standardized plans from which individuals may purchase health insurance eligible for federal subsidies. Under the PPACA, all exchanges must be fully certified and operational by January 1, 2014.

Federal Poverty Levels (FPL)

The following are the 2012 FPLs for family sizes of one to three people.

Family Size	100% of FPL	133% of FPL	200% of FPL
1	$11,170	$14,856	$22,340
2	$15, 130	$20,123	$30,260
3	$19,090	$25,390	$38,180

COMMITTEE ACTION

Public Health Committee

Joint Favorable Substitute
Yea 18 Nay 10 (03/29/2012)